DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 11/24/12

PRINTED: 10/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445276	A. BUILDING _____ B. WING _____	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND VILLAGE CARE AND REHABILITATION CENTER	136 DAVIS LANE LAFOLLETTE, TN 37766

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #30007, were completed on October 10, 2012, at Cumberland Village Care and Rehabilitation. No deficiencies were cited related to complaint investigation #30007 under 42 CFR PART 482.13, Requirements for Long Term Care Facilities.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cumberland Village Care & Rehabilitation Center does not admit that the deficiencies listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding	F 272	and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiencies." 1. Resident # 130 was assessed for bowel and bladder incontinence on 10/10/12 by an RN and found to be incontinent. 2. An audit of incontinent residents was conducted by the Director of Nursing or designee on 10/19/12. Other incontinent residents had current bowel and bladder assessments. 3. The Director of Nursing or designee conducted re-education with licensed staff for completion of bowel and bladder assessments on incontinent residents by 10/26/12. 4. The Director of Nursing or designee will complete an audit of bowel and bladder assessments on incontinent residents weekly for four weeks and monthly for two months to ensure compliance is achieved and sustained. The Administrator or designee will review and analyze the results of the audit of	10/26/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/26/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to perform a bowel and bladder assessment for one resident (#130) of thirty-five residents reviewed in Stage two. The findings included: Resident #130 was readmitted to the facility on May 31, 2012, with diagnoses including Muscle Weakness, Alzheimer's Disease, Diabetes, and Hypertension. Medical record review of the quarterly Minimum Data Set (MDS) dated September 5, 2012, revealed the resident was incontinent of bowel and bladder. Interview with the Assistant Director of Nursing on October 10, 2012, at 9:22 a.m., at the nurses' station, confirmed there was no documentation the resident was assessed for bowel and bladder incontinence.	F 272	bowel and bladder assessments on incontinent residents during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary. **F 282** **1.** Resident # 72's care plan was updated to reflect their meal delivery preference on 10/10/12. The resident was offered a "take out box" on 10/10/12 and refused. **2.** An audit of other residents with weight loss care plans that have adaptive equipment was conducted by the Registered Dietician or designee on 10/23/12. Those residents with weight loss care plans that have adaptive equipment were reviewed and no other issues were identified. 3. The Registered Dietician or designee conducted re-education with dietary staff on following tray cards as written by 10/26/12. Nursing management conducted re-education with nursing staff serving meals to follow care plans and care cards by 10/26/12. **4.** The Registered Dietician or designee will complete an audit of residents with weight loss care plans that have adaptive equipment weekly for four weeks and monthly for two months to ensure compliance is achieved and sustained.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	The Administrator or designee will review and analyze the results of the audit for residents with weight loss care plans that have adaptive equipment during the	

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F 282	Continued From page 2 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow the care plan for one resident (#72) of thirty-five residents reviewed in Stage two. The findings included: Resident #72 was admitted to the facility on April 29, 2004, with diagnoses including Hallucinations, Urinary Tract Infection, Psychosis, Alzheimer's Disease, Chronic Airway Obstruction, Congestive Heart Failure, and Depressive Disorder. Medical record review of the Care Plan dated October 5, 2012, revealed "...Actual alteration in nutrition status related to significant weight loss of 18.2# (pounds) in 180 d (days) due to...illness, and progression of the disease process Dx (diagnosis) Alzheimers, Lung CA (cancer)...increased behaviors and paranoia...refusing facility meals due to paranoia that it is contaminated with...meds (medications)...provide meals in take out boxes to encourage meal completion..." Observation on October 10, 2012, at 8:05 a.m., revealed the resident had received the breakfast meal. Continued observation revealed the food was not provided in a "take out" box.	F 282	monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	

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F 282	Continued From page 3 Observation and interview with Licensed Practical Nurse (LPN) #1, on October 10, 2012, at 8:10 a.m., in the resident's room, confirmed the resident's food was not served in a "take out" box.	F 282 F 315	1. The licensed nurse called the physician and obtained an appropriate diagnosis for resident # 24's Foley catheter on 10/10/12.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to assess one resident (#24) for the use of an indwelling urinary catheter of thirty-five residents reviewed in Stage two. The findings included: Resident #24 was admitted to the facility on October 2, 2012, with diagnoses of Intracerebral Hemorrhage, Hypertension, Anxiety Disorder, Chronic Pain, Multiple Myeloma, and Unspecified Renal Failure. Medical record review of the admission Nursing Assessment dated October 2, 2012, revealed the resident had long and short term memory	F 315	2. An audit of residents with Foley catheters was conducted by the Director of Nursing or designee on 10/10/12. Those residents with Foley catheters had an appropriate diagnosis. 3. The Director of Nursing or designee conducted re-education with licensed nursing staff on ensuring residents with Foley catheters have an appropriate diagnosis by 10/26/12. 4. The Director of Nursing or designee will complete an audit of residents with Foley catheters weekly for four weeks and monthly for two months to ensure compliance is achieved and sustained. The Administrator or designee will review and analyze the results of the audit for residents with Foley catheters during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	

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F 315	Continued From page 4 problems, was oriented to person only, and had severely impaired cognition for daily decision making. Medical record review of the admission Nurse's Note dated October 2, 2012, revealed the resident was admitted with an indwelling urinary catheter. Medical record review revealed no documentation the resident had been assessed for the appropriate use of the catheter, including the diagnosis for catheter justification. Observation in the resident's room on October 8, 2012, revealed the resident had an indwelling urinary catheter connected to a bedside drainage bag. Review of facility policy, Indwelling Catheter Use, revealed, "...Indwelling catheters are used when ordered by a physician to treat a specific medical reason...When a resident is admitted with an indwelling catheter but does not have a justifiable reason for use, the licensed nurse contacts the physician to request an order from the primary care physician to discontinue the use of the indwelling catheter, and documents accordingly..." Interview with the Assistant Director of Nursing at the North Hall nurse's station on October 10, 2012, at 9:30 a.m., confirmed the resident did not have a diagnosis for the justification of the catheter usage.	F 315		